

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295021</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 10/06/2010</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHERN NEVADA MEDICAL AND REHABILITATION CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>2945 CASA VEGAS STREET LAS VEGAS, NV 89109</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This Statement of Deficiencies was generated as a result of a revisit survey conducted at your facility on 10/5/10 through 10/6/10. The revisit was in response to the findings of a previous Medicare Recertification survey conducted at your facility on 5/24/10 and the first revisit conducted at your facility on 7/20/10. The survey was conducted in accordance with 42 Code of Federal Regulations (CFR) Chapter IV Part 483 Requirements for Long Term Care Facilities.</p> <p>The sample size was 13 residents, which was 60% of the original sample size of 21.</p> <p>Note: The facility's Plan of Correction (POC) dates for the 7/20/10 revisit survey were 8/16/10.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The following deficiencies were identified:</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.